House Bill 1234 (AS PASSED HOUSE AND SENATE)

By: Representatives Channell of the 116th, Cooper of the 41st, Parrish of the 156th, Stephens of the 164th, Hugley of the 133rd, and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to enact the "Medicaid Care Management Organizations Act"; to provide that care management organizations that contract with the Department of Community Health to provide health care services for Medicaid and PeachCare for Kids recipients meet certain requirements; to provide a short title; to provide for definitions; to provide that care management organizations are subject to certain laws relating to health maintenance organizations, managed health care plans, and insurance generally; to provide requirements relating to reimbursement for emergency health care services; to provide for requirements relating to critical access hospitals; to provide for coverage for newborn infants until discharged from the hospital; to provide for bundling of provider complaints and appeals; to provide for binding arbitration; to provide for interest payments on denied claims which are reversed; to require care management organizations to maintain a website for the processing of claims and to search for health care providers; to provide for standardized processing times for claims; to prohibit care management organizations from requiring health care providers to purchase or participate in other plans of the organization as a condition; to provide requirements for participation by dentists; to provide for claims to a responsible health organization; to require that the provisions of this Act are included in new and renewal agreements with care management organizations and health care providers; to provide for Hospital Statistical and Reimbursement Reports from the Department of Community Health; to provide for applicability; to amend Code Section 49-4-153 of the Official Code of Georgia Annotated, relating to administrative hearings and appeals relative to the Medicaid program, so as to provide that an administrative law judge can consolidate complaints or claims against a care management organization; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

"CHAPTER 21A

33-21A-1.

This chapter shall be known and may be cited as the 'Medicaid Care Management Organizations Act.'

33-21A-2.

As used in this chapter, the term:

(1) 'Care management organization' means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title, and which has entered into a contract with the Department of Community Health to provide or arrange health care services on a prepaid, capitated basis to members.

(2) 'Coordination of care' means early identification of members who have or may have special needs; assessment of a member's risk factors; development of a plan of care; referrals and assistance to ensure timely access to providers; actively linking the member to providers, medical services, and residential, social, and other support services where needed; monitoring; continuity of care; and follow-up and documentation, all as further described pursuant to the terms of the contracts between the Department of Community Health and the care management organizations.

(3) 'Critical access hospital' means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital and that is recognized by the Department of Community Health as a critical access hospital for purposes of Medicaid.

(4) 'Emergency health care services' means health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(5) 'Health care provider' or 'provider' means any person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Georgia that has contracted with a care management organization to provide health care services to members.

(6) 'Health care services' has the same meaning as in paragraph (5) of Code Section 33-21-1.

(7) 'Health maintenance organization' means an entity which has been issued a certificate of authority by the Commissioner of Insurance pursuant to Chapter 21 of this title to establish and operate a health maintenance organization.

(8) 'Hospital Statistical and Reimbursement Report' or 'HS&R report' means a report created by a care management organization, using the same format that is used by the Department of Community Health in completing HS&R reports, that includes data related to an individual hospital, including aggregate statistics and reimbursement data for all Medicaid recipients who are covered by the care management organization and who received health care services at such hospital during a specific fiscal year, including data regarding services that were provided out of network. HS&R reports are utilized by the Department of Community Health for purposes of the Indigent Care Trust Fund´s disproportionate share hospital survey and are also utilized by hospitals to claim payments under medicare´s disproportionate share hospital program.

(9) 'Medicaid' means the joint federal and state program of medical assistance established by Title XIX of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 7 of Chapter 4 of Title 49.

(10) 'Member' means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(11) 'PeachCare for Kids' means the State of Georgia´s State Children´s Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 13 of Chapter 5 of Title 49.

(12) 'Post-stabilization services' means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member´s condition.

(13) 'Responsible health organization' means the entity that a health care provider reasonably identifies to be responsible for providing or arranging health care services for a patient who is a Medicaid or PeachCare for Kids recipient after the provider has properly conducted an eligibility verification in accordance with the procedures of the Department of Community Health.

33-21A-3.

(a) A care management organization shall be required to obtain a certificate of authority as a health maintenance organization pursuant to Chapter 21 of this title prior to providing or arranging health care for members pursuant to a contract with the Department of Community Health. On and after the date of issuance of its certificate of authority as a health maintenance organization, a care management organization shall comply with all provisions relating to health maintenance organizations and all provisions relating to managed health care plans, with the exception of Code Section 33-20A-9.1.

(b) The Commissioner of Insurance shall not have the authority to approve, disapprove, or set rates paid by the Department of Community Health to a care management organization or paid by a care management organization to a health care provider.

(c) The Commissioner of Insurance shall not have the authority to approve, disapprove, or modify any plan offered by a care management organization or any contract between a care management organization and the Department of Community Health.

(d) Nothing in this chapter shall be interpreted as altering the authority of the commissioner of community health.

33-21A-4.

(a) In particular, but without limitation, a care management organization shall not:

(1) Deny or inappropriately reduce payment to a provider of emergency health care services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or

(2) Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.

(b) In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

(1) The age of the patient;

(2) The time and day of the week the patient presented for services;

(3) The severity and nature of the presenting symptons;

(4) The patient´s initial and final diagnosis; and

(5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

A care management organization shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services. The Department of

Community Health may develop and publish a list of additional standards to be used by care management organizations to maximize the identification and accurate payment of claims for emergency health care services.

(c) If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization´s member, the care management organization shall reimburse the noncontracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly.

33-21A-5.

(a) A critical access hospital must provide notice to a care management organization and the Department of Community Health of any alleged breaches in its contract by such care management organization.

(b) If a critical access hospital satisfies the requirement of subsection (a) of this Code section, and if the Department of Community Health concludes, after notice and hearing, that a care management organization has substantively and repeatedly breached a term of its contract with a critical access hospital, the department is authorized to require the care management organization to pay damages to the critical access hospital in an amount not to exceed three times the amount owed. Notwithstanding the foregoing, nothing in this Code section shall be interpreted to limit the authority of the Department of Community Health to establish additional penalties or fines against a care management organization for failure to comply with the contract between a care management organization and the Department of Community Health.

33-21A-6.

(a) Each care management organization shall pay for health care services provided to a newborn infant who is born to a mother who is a member currently enrolled with that care management organization until such time as the newborn is finally discharged from all inpatient care to a home environment subject to approval by the federal Centers for Medicare and Medicaid Services. For a newborn infant whose mother is enrolled in a Medicaid program under which she receives Medicaid benefits directly from the Department of Community Health, the Department of Community Health shall pay for health care services provided to the newborn until such time as the newborn is finally discharged from all inpatient care to a home environment.

(b) In the event a newborn is disenrolled from a care management organization and re-enrolled into the Medicaid fee-for-service program conducted directly by the

Department of Community Health, the care management organization shall ensure the coordination of care for that child until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

33-21A-7.

(a) In reviewing provider complaints or appeals related to denial of claims, a care management organization shall allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

(b) Each care management organization shall allow a provider that has exhausted the care management organization´s internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative review process described in subsection (e) of Code Section 49-4-153 or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the care management organization and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney´s fees, shall be shared equally by the parties.

(c) For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the care management organization to the provider. A care management organization shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic

claims, a CMS Form 1500 for nonelectronic claims, or any claim prescribed by the Department of Community Health.

(d) Each care management organization shall maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically. To the extent a provider has the capability, each care management organization shall submit payments to providers electronically and submit remittance advices to providers electronically within one business day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

(e) Each care management organization shall post on its website a searchable list of all providers with which the care management organization has contracted. At a minimum, this list shall be searchable by provider name, specialty, and location. At a minimum, the list shall be updated once each month.

(f) The Department of Community Health shall require each care management organization to utilize the same timeframes and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the timeframes and deadlines that the Department of Community Health uses on claims it pays directly.

(g) No care management organization shall, as a condition of contracting with a provider, require that provider to participate or accept other plans or products offered by the care management organization unrelated to providing care to members. Any care management organization which violates this prohibition shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A care management organization shall not reduce the funding available for members as a result of payment of such penalties.

(h) No health care provider shall, as a condition of contracting with a care management organization, require that a care management organization contract with or not contract with another health care provider. Any health care provider which violates this subsection shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A health care provider shall not terminate an agreement with a care management organization as a result of payment of such penalties.

33-21A-8.

(a) Except as provided in subsection (b) of this Code section, no care management organization or agent of such care management organization shall deny any dentist from participating in the Medicaid and PeachCare for Kids dental program administered by such care management organization if:

(1) Such dentist has obtained a license to practice in this state and is an enrolled provider who has met all of the requirements of the Department of Community Health for participation in the Medicaid and PeachCare for Kids program; and

(2)(A) The licensed dentist will provide dental services to members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, each care management organization shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the care management organization´s Medicaid and PeachCare for Kids dental programs;

(B) The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by the Department of Community Health, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services; or

(C) Such care management organization fails to establish to the satisfaction of the Department of Community Health that a sufficient number of general dentists and specialists have contracted with the care management organization to provide covered dental services to members in the geographic region.

(b) A care management organization may decline to contract with a dentist who meets the requirements of subsection (a) of this Code section if such dentist has had his or her license to practice dentistry sanctioned in any manner or fails to meet the credentialing criteria established by the care management organization. Any dentist denied on this basis shall be entitled to a hearing before an administrative law judge as set forth in subsection (e) of Code Section 49-4-153.

(c) The Department of Community Health shall also provide a means for dentists to request an annual hearing to determine whether a condition described in subparagraph (B) or (C) of paragraph (2) of subsection (a) of this Code section exists. The department may compel the attendance of care management organizations or agents of care management organizations to attend such hearings. The department may request additional information as a result of the hearing, and it shall consider matters raised in the hearing when deciding whether a condition described in subparagraph (A) or (B) of paragraph (2) of subsection (a) of this Code section exists.

33-21A-9.

(a) If a provider submits a claim to a responsible health organization for services rendered within 72 hours after the provider verifies the eligibility of the patient with that responsible health organization, the responsible health organization shall reimburse the provider in an

amount equal to the amount to which the provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the provider´s claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the provider.

(b) If a provider verifies the eligibility of a patient as set forth in subsection (a) of this Code section, and if a provider determines that a person other than the responsible health organization to which it has submitted a claim is responsible for Medicaid or PeachCare for Kids coverage of the patient at the time the service was rendered, the provider may submit the claim to the person that is responsible for Medicaid or PeachCare for Kids coverage and that person shall reimburse all medically necessary services, without application of any penalty for failure to file claims in a timely manner, for failure to obtain prior authorization, or for the provider not being a participating provider in the person´s network, and the amount of reimbursement shall be that person´s applicable rate for the service if the provider is under contract with that person or the rate paid by the Department of Community Health for the same type of claim that it pays directly if the provider is not under contract with that person.

33-21A-10.

(1) On and after the effective date of this chapter, the Department of Community Health shall include provisions in all new or renewal agreements with a care management organization, which require the care management organization to comply with all provisions of this chapter.

(2) On and after the effective date of this chapter, a care management organization shall not include any provisions in new or renewal agreements with providers entered into pursuant to the contract between the Department of Community Health and the care management organization, which are inconsistent with the provisions of this chapter.

33-21A-11.

Upon request by a hospital provider related to a specific fiscal year, a care management organization shall, within 30 days of the request, provide that hospital with an HS&R report for the requested fiscal year. Any care management organization which violates this Code section by not providing the requested report within 30 days shall be subject to a penalty of $1,000.00 per day, starting on the thirty-first day after the request and continuing until the report is provided. It is the intent of the General Assembly that such penalty be collected by the Department of Community Health and deposited into the Indigent Care

Trust Fund created pursuant to Code Section 31-8-152. A care management organization shall not reduce the funding available for health care services for members as a result of payment of such penalties.

33-21A-12.

To the extent any provision in this chapter is inconsistent with applicable federal law, rule, or regulation, the applicable federal law, rule, or regulation shall govern."

SECTION 2.

Code Section 49-4-153 of the Official Code of Georgia Annotated, relating to administrative hearings and appeals relative to the Medicaid program, is amended by revising paragraph (1) of subsection (e) as follows:

"(1) A dentist acting pursuant to subsection (b) of Code Section 33-21A-8 or a provider of medical assistance may request a hearing on a decision of a care management organization with respect to the provisions set forth in subsection (b) of Code Section 33-21A-8 or with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department of Community Health. The Department of Community Health shall, within 15 business days of receiving the request for hearing from the provider, transmit a copy of the provider's request for hearing to the Office of State Administrative Hearings; but shall not be a party to the proceedings. The provider's request for hearing shall identify the care management organization with which the provider has a dispute, the issues under appeal, and specify the relief requested by the provider. The request for hearing shall be filed no later than 15 business days after the provider of medical assistance receives the decision of the care management organization which is the basis for the appeal. Notwithstanding any other provision of this title, an administrative law judge appointed pursuant to paragraph (2) of this subsection shall be authorized to allow a provider of medical assistance to consolidate pending complaints or claims against a care management organization that are based on the same or similar payment or coverage issues, as determined by such administrative law judge. Such consolidation shall include disposition of the same or similar claims through a single hearing that adjudicates the total amount of such consolidated claims."

SECTION 3.

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.